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Clinical Implications of Management Decisions

A woman visited a rural family planning clinic for the fifth time to get pills. The first time she received just one cycle of pills; each of the four succeeding visits she was given three cycles of pills. It took her 3 hours in each direction to come to the clinic and 30 minutes to an hour to get her pills. Each clinic visit cost her a day away from her field, making life just a bit more difficult for her. But she loved knowing that she couldn't get pregnant, so she returned. She never returned for her sixth pill visit, because her child was injured the day before the appointed date. Caring for him kept her from returning for the next 3 weeks. Without contraceptive protection, she became pregnant. The pregnancy was in her tubes. She died during the 3-hour trip to the hospital.

Reproductive health care is probably burdened with more laws, rules, biases, and administrative policies than any other area of medicine. Each administrative ruling, regulation, or protocol can act as a major barrier to the provision of high-quality services. For example, a provider may be limited to dispensing only one to three packages of oral contraceptives (OCs) at a single visit, even though a woman is far more likely to continue to take OCs if she can get a year supply of pills at a time.

Medical practice is dramatically influenced by administrative decisions made because of national laws, decisions made by a ministry of health or a regional health board, and medical policies established for a local clinic or even by an individual physician. Administrative decisions affect not only the services provided but the patient's choice and successful use of contraceptives. The motivation behind these administrative decisions and policies is often religious, political, social, or economic and does not always take into consideration the quality of the services provided each client. Family planning providers can be caught in the middle between the administrative decisions and their personal, professional interpretation of what is needed to provide high-quality services. Providers may confront serious dilemmas when forced to choose between compromising the quality of care by adhering to a short-sighted policy and endangering professional relationships by circumventing the policy.

Thus, it is important that providers play an active role in developing national service policies, norms, and procedures. In general, policies state the philosophy guiding family planning services and set forth rules and regulations. Norms, or standards, specify the minimally acceptable levels of performance expected of the providers. Procedure guidelines, or protocols, detail the step-by-step instructions for performing clinical tasks.

Examples of some of the administrative questions that might affect the clinical management of patients are presented in Table 24:1. Apply these questions to your own program and keep in mind the following important questions:

- What was the reason for this policy?
- What was the original intent of this policy?
- What is the impact of the policy on the client and the quality of services?
- What policy changes need to occur and how?

Reproductive health care providers must be responsive to the needs of the client. The goal is to provide safe, effective services in a manner acceptable to the clients. Reproductive health care providers must evaluate their programs' policies and the effect these policies have on the health care provided. Some of the administrative decisions providers should consider, the possible impact of these decisions on the clients, and current recommended practices are presented in Table 24:2. This table is arranged to correspond to the policy questions posed in Table 24:1.

Around the world, reproductive health decisions made by individual clients and their providers are strongly influenced by the legal, social, economic, and religious milieu of the place where they are made. If providers want to change medical practice to improve the health of individual clients, they must first examine the policies that affect their clients and their own practice of reproductive care (both the individual program's policies and the country's laws or policies that govern reproductive health care). They must review the guidelines in their national reproductive health programs to make sure they maximize both access to and the quality of family planning services. They must then move out into the legislative arena, religious institutions, the media, and the field of public health to bring about new or modified laws and regulations that permit the practices they deem best for individuals and couples.

Table 24:1 Service delivery policies, norms, and procedures

What are your program's service delivery policies, norms, and procedures?

Intrauterine devices (IUDs)

- Must a woman be menstruating to have an IUD inserted?
- Are uterine sounds available?
- Are antibiotics available to treat pelvic infections, and are they available in sufficient quantity? Are staff trained to handle infections?
- Is the levonorgestrel IUD available for clinicians?
- Is a policy in effect directing clinicians to remove the Copper T 380A after 3, 4, 5, or 6 years?

Oral contraceptives (pills)

- Must oral contraceptives be prescribed by a physician?
- Must new pill clients have a pelvic exam before beginning pills? Are Pap smears mandatory for all pill clients?
- How many packages of pills may a woman obtain initially? For resupply? After using the pill for a year?
- Are clients required to wait until the first postpartum menstrual period to begin oral contraceptives?
- Can nonsmoking women 35 years and older without cardiovascular risks be provided combined birth control pills?

Emergency (postcoital) contraceptives

- Are emergency contraceptive pills available for the 72 hours following unprotected intercourse?
- Is information about the availability of emergency contraception part of the standard for delivering family planning service?
- Is the Copper T 380A inserted as an emergency postcoital contraceptive in the 5 days following unprotected intercourse?

Table 24:1 Service delivery policies, norms, and procedures (Continued)

Sterilization

- How are the surgeons paid who perform sterilization procedures (per procedure, per session, or per hour)?
- Must husbands or partners sign an authorization form for their wives or partners to obtain a tubal ligation?
- Is there adequate operating room time for performing tubal ligations?
- Are there rules indicating how many children a woman must have and what age she must be before she can have a tubal ligation?

Barrier methods

- How many condoms can be given to a woman or a man at a single visit?
- Can people obtain condoms without providing their names?

Injectables or implants

- Are Norplant implants and Depo-Provera available and accessible at all clinic sites?
- Are nurses or physician assistants trained to insert and to remove Norplant implants?

Sexually transmitted infections (STIs)

- Do you routinely offer to screen women for infection with the human immunodeficiency virus (HIV) and other STIs?
- Do you routinely take a sexual history to determine the need for STI testing?
- Is a microscope available to clinicians who perform pelvic examinations?

Table 24:1 Service delivery policies, norms, and procedures (Continued)

Adolescent clients

- Are adolescents encouraged to consider abstinence as an option?
- Does the program permit providing contraceptives to unmarried or single women? Unmarried men? Must an unmarried adolescent have parental consent in order to receive contraceptives?
- Must an adolescent have a pelvic exam before getting pills?
- Must an adolescent female have established regular periods before being given the pill?
- Does your program have separate hours or facilities and trained providers to serve adolescents?
- Is emergency contraception offered to adolescents?

Clinic management

- Are appointments in the clinic made on a first-come, first-served basis?
- Can a woman with an emergency be seen by a provider immediately?
- Is your clinic open on weekends or in the evening?
- Does the form used for the documentation of a contraceptive visit ask questions about the frequency of intercourse, number of sexual partners, age of first intercourse, and history of STIs?
- Must a chaperone be present in the examination room for both male and female examiners?
- Does the clinic provide privacy to the client during interviews and during the physical exam?
- Do the providers speak the same language as the clients?
- Are providers paid differential incentives for the provision of different methods?
- Is there a steady, dependable flow of contraceptives and supplies from the central depot to the clinic or provider?
- Must husbands sign a consent form for their wives to receive family planning services?
- Can clients receive resupplies quickly, or must they wait with clients coming for other services?

Table 24:2 Administrative decisions and their impact on the client/patient

Administrative decision	Impact on client/patient	Recommended practices/policies
Intrauterine devices (IUDs)		
A woman must be menstruating to have an IUD inserted. The policy applies to all women, including women who have not had sexual intercourse in the recent past, postpartum women, and women who have traveled long distances.	Insertion of IUD may be unnecessarily delayed and extra visits and pelvic exams required. It may be inconvenient, uncomfortable, or impossible for a women to return to a clinic during her menstrual period.	Permit IUD insertion for nonmenstruating women or if she: • is partpartum and has not had intercourse since delivery • is postpartum and all acts of intercourse have been protected • has not had intercourse since last menses • has been taking pills correctly • has just had her menses
Uterine sounds are not available in busy clinic inserting IUDs.	Clinician forced to rely on pelvic exam to determine size, axis, and flexion of the uterus. Perforation may result when mistakes are made.	Adequate sterile sounds should routinely be available if IUDs are being inserted.

Table 24:2 Administrative decisions and their impact on the client/patient (Continued)

Administrative decision	Impact on client/patient	Recommended practices/policies
Intrauterine devices (IUDs) (*continued*)		
Provider inserting IUDs not allowed to manage infection. Antibiotics for a full 10- to 14-day treatment of pelvic inflammatory disease are not available for clinic to dispense.	Clinicians may refuse to insert the IUD at all if antibiotic treatment is unavailable should a pelvic infection occur. Untreated infections may lead to severe complications. Clinicians may be unwilling to insert IUDs if they believe follow-up is inadequate. The clinician who diagnoses a borderline case of pelvic inflammatory disease (PID) may use a "watch and wait" approach that leads to a more serious infection. Removing the IUD might have been more appropriate management.	In most instances, clinic providers should be able to manage the complications of the contraceptives they provide, including PID in IUD users. Alternatively, providers should be trained to recognize symptoms of common complications and refer patients to a larger clinic for treatment. Antibiotics such as tetracycline (or doxycycline) and ampicillin should be available for treating women with PID.
The levonorgestrel (LNg 20) IUD is not available.	An IUD that decreases a woman's risk for dysmenorrhea, PID, menorrhagia, and uterine myoma is withheld from use.	The LNg 20 IUD should be approved by the country's regulatory agency and made available and accessible to women.
The Copper T 380A must be removed after 4 or 5 years.	Women must have a highly effective, well-tolerated device removed too soon.	The Copper T 380A may be left in utero for at least 10 years.

Table 24:2 Administrative decisions and their impact on the client/patient (Continued)

Administrative decision	Impact on client/patient	Recommended practices/policies
Oral contraceptives (OCs)		
OCs can only be prescribed by a physician.	Because most physicians in most developing countries live in urban areas, many rural women may be unable to obtain pills.	Trained nurses and paramedical workers can provide pills by using a checklist to screen for contraindications. Physicians can handle complications and difficult cases and supervise the nurses and paramedical workers.
A Pap smear must be performed before a woman can begin oral contraceptives. A Pap smear must be performed annually for every woman given oral contraceptives.	If Pap smears are required to begin pills, many women, especially rural women, may have to rely on less effective methods until they get to a clinic. They may become pregnant while waiting for an opportunity or the money to visit a clinic. If Pap smears are not done at a particular clinic or materials are temporarily unavailable, oral contraceptives may not be offered.	Pap smears are a desirable routine medical screening procedure for sexually active women. However, because the contraceptive and noncontraceptive benefits of oral contraceptives give them a desirable benefit-to-risk ratio in most settings, they should be offered to women even if routine Pap smears are not available.

Table 24:2 Administrative decisions and their impact on the client/patient (Continued)

Administrative decision	Impact on client/patient	Recommended practices/policies
Oral contraceptives (OCs) (*continued*)		
A limit of 1-3 packages of OCs is set as the maximum provided at one visit. Women must return to a clinic for OCs 4-12 times a year.	Clients may be more likely to discontinue OCs. Methods that involve a "single decision" may be far more attractive than OCs. For example, an IUD may become more attractive than OCs even if a woman has reasons to avoid an IUD. Use of OCs is difficult for women who must frequently travel long distances for resupply.	In deciding the number of cycles to provide, always be aware of the distance and cost to the client to reach the provider. After a woman has used OCs correctly for 13 months without side effects, complications, or problems, strongly consider offering up to 13 cycles of OCs at a time.
A post partum woman must have had her first period before OCs are begun.	OCs are eliminated as an option for a woman who may ovulate and become pregnant before her first postpartum menstrual period.	• Provide OCs to nonbreastfeeding women just after delivery or encourage women to start OCs 2 to 3 weeks postpartum. • If a woman is seen 6 weeks portpartum, is not breastfeeding, has not had intercourse, and has not had a menstrual period, start OCs but have patient use condoms in addition to the first cycle of OCs.
OCs are not to be provided to breastfeeding women.	Breastfeeding women may become pregnant.	Strongly consider having progestin-only contraceptives available for breastfeeding women.

Table 24:2 Administrative decisions and their impact on the client/patient (Continued)

Administrative decision	Impact on client/patient	Recommended practices/policies
Oral contraceptives (OCs) (*continued*)		
Nonsmoking women aged 35 years and older are not to be provided OCs, even if they have no risk factors for cardiovascular disease other than age.	Providers are unable to prescribe a safe, effective method of birth control to older women. The beneficial effects of OCs in preventing ovarian and endometrial cancer are not available for these women.	Permit nonsmoking women 35 to 40 years of age to be provided OCs with less than 50 mcg of estrogen—as long as they have no other risk factors for cardiovascular disease, such as hypertension or diabetes.
Emergency contraceptive pills (ECPs)		
ECPs are not readily available.	A method that could reduce the risk of unintended pregnancy by 75% is denied to women, leading to increased abortions, many of which are illegal and performed in a dangerous manner.	Provide information to patients and providers about ECPs and post-coital insertion of the Copper T 380A. Use OCs in high doses within 72 hours of unprotected intercourse to prevent unintended pregnancies.
Use of the Copper T 380A as a postcoital contraceptive is discouraged.	A method even more effective than ECPs is denied to women. In addition, these women miss the opportunity to initiate long-term use of an extremely effective method.	Change policies to encourage use of copper-releasing IUDs as emergency postcoital contraceptives within 5 days of unprotected intercourse.

Table 24:2 Administrative decisions and their impact on the client/patient (Continued)

Administrative decision	Impact on client/patient	Recommended practices/policies
Sterilization		
Husband or partner must authorize a tubal ligation for his wife or partner.	Tubal ligation may be eliminated as an option for an individual woman whose husband or partner wishes to control the decision as to how many children she will have.	Although it is clearly desirable for men and women to discuss and agree, women who bear children and carry a major share of the responsibility for rearing them should generally be able to decide to stop having children.
Emergency gynecologic and obstetric procedures take precedence over tubal ligations when operating room time is allocated.	Tubal ligations are delayed for women or never performed at all. Unplanned pregnancies occur.	Increase the amount of operating time, supplies, and personnel available to perform tubal ligations.
Women must have a certain number of children (e.g., three) and be a certain age (e.g., 30) before having a tubal ligation.	Women who know they want to stop childbearing are potentially unable to do so. Young women who want to finish their childbearing must endure the risks and costs of less effective contraceptive methods.	Consider eliminating laws or medical regulations limiting sterilization to women on the basis of the number of children they have had and their age.

Table 24:2 Administrative decisions and their impact on the client/patient (Continued)

Administrative decision	Impact on client/patient	Recommended practices/policies
Sterilization (*continued*)		
Physicians are paid for the sterilizations they perform on a per-case or per-hour basis.	Physicians who are paid to work fast to earn more money may work too fast and thereby increase the risk of injury to the patient. Physicians who are paid on a per-case basis may pressure clients into sterilization to increase their wages and may not permit clients to change their minds before undergoing sterilization.	Clients should freely and voluntarily choose sterilization without pressure and be provided as high a quality of surgery as possible. Consider reimbursing physicians with a salary or on a per-session basis to avoid any possibility of coercing patients or providing less than the best care possible.
Barrier methods		
Only 3, 6, or 12 condoms may be provided at one visit. Condoms in large numbers are either unavailable, expensive, or embarrassing to obtain.	Makes condoms less attractive as an interim (e.g., between IUD removal and initiation of OCs) or long-term method. Relegates condom use to prevention of STIs. Diminishes the desirability and the credibility of condoms in the eyes of both providers and patients.	Consider offering large numbers of condoms at each visit (e.g., 40 to 100 condoms). Provide condoms anonymously to men or women. Encourage patients to give them to friends and relatives.
No contraceptive services are to be provided without documentation, including condoms to adolescent boys and older men.	Usually means that everyone receiving any contraceptive services must have a history taken or a physical exam performed. These practices can discourage people from using services.	Provide contraceptives such as condoms and vaginal spermicides anonymously without requiring that individuals officially "sign up" or be examined.

Table 24:2 Administrative decisions and their impact on the client/patient (Continued)

Administrative decision	Impact on client/patient	Recommended practices/policies
Injectables or implants		
Norplant implants or injectables will be available for women who want to use these methods.	An important "single decision method" is available that will provide highly effective contraception for the person not wishing to consider sterilization at this time.	Gaining official clearance for Norplant is an important priority. Training programs for inserting and removing implants must be established. Follow-up systems must be functional to retrieve implants at the time of expiration.
Sexually transmitted infections (STIs)		
Screening will be performed on a routine, voluntary basis on family planning clinic clients.	Discussion of sexual history and explanation of HIV infection becomes part of patient management. Screening is time-consuming and expensive. Condom use is encouraged.	Offer volunteer HIV screening and provide adequate training and personnel to take the required history and to do the necessary counseling.
Sexual history is not routinely taken.	Sexual problems are not identified.	Several routine questions should be asked of all patients and included on history forms.
Microscopes are not provided to local family planning clinics for evaluation of vaginitis or urinary tract infections.	Trichomonas, bacterial vaginosis, gonorrhea, and Candida infections are more difficult to diagnose. Clinicians have to guess the diagnosis based on symptoms and physical characteristics of discharge.	Make inexpensive microscopes and necessary supplies available at all clinic sites where pelvic exams are performed. Train personnel to manage STIs syndromically (see Chapter 6) in the absence of testing capability.

Table 24:2 Administrative decisions and their impact on the client/patient (Continued)

Administrative decision	Impact on client/patient	Recommended practices/policies
Adolescent clients		
An adolescent female must be married, have a baby, or have parental consent to receive contraceptive services.	Unmarried adolescent females who are sexually active may get pregnant. Whatever the policy, it may present an ethical dilemma for a provider. Those who are willing to serve an adolescent may feel pressure to indicate on the chart that they are prescribing OCs for noncontraceptive indications such as acne, dysmenorrhea, or heavy periods rather than for contraception.	Adolescent females sometimes have intercourse without parental consent. Make sure they understand that abstinence is an option, but permit them to obtain contraceptives to prevent an unwanted pregnancy. Sex education programs and the ready availability of contraceptives prevent unwanted pregnancies and abortions.
A complete pelvic exam must be performed for every adolescent female obtaining OCs.	Initial pelvic exam may be uncomfortable for young women. Initial pelvic exam may deter adolescents females from coming to family planning clinics.	Flexibility is particularly desirable in this situation. Permit and encourage abbreviated exams. Have small speculae available to minimize discomfort. Consider providing OCs without the absolute requirement of a pelvic exam.
An adolescent female must have regular periods before being given the pill.	Pregnancies will occur in young teenagers who are denied access to OCs. Ovulation may precede the onset of regular menses in some women.	Provide OCs to young women who are sexually active and do not use condoms or another contraceptive. Make them aware of the risks of HIV and other STIs.

Table 24:2 Administrative decisions and their impact on the client/patient (Continued)

Administrative decision	Impact on client/patient	Recommended practices/policies
Adolescent clients (*continued*)		
Separate hours or facilities for adolescents are not provided.	Because young women and men may feel uncomfortable visiting during regular clinic hours, they may not obtain needed contraceptive services.	Consider providing separate hours or facilities for adolescents. Train providers to understand the emotional, sexual, and reproductive health needs of adolescents.
Clinic management		
Appointments are made on a first-come, first-served basis.	Tends to produce long waits. Permits women and men to come to the clinic at any time.	Provide care to some patients with an appointment system and make every effort to honor those appointments. Permit some patients to receive care on a first-come, first-served basis.
Appointments for complications and pregnancy tests are handled like routine appointments.	A delay in exam may adversely affect the outcome in cases of IUD expulsion, vaginal and pelvic infection, and urinary tract infections. Pregnancy termination, where available, may be delayed.	Appointment clerks must be taught a system of priorities (triage) so that women with urgent needs can be seen as soon as possible. Unprotected intercourse that could lead to unwanted pregnancy should be considered a high priority.

Table 24:2 Administrative decisions and their impact on the client/patient (Continued)

Administrative decision	Impact on client/patient	Recommended practices/policies
Clinic management		
Clinic hours limited to 8 am to 4 pm, Monday through Friday or to 1 day a week. No evening or weekend clinics.	Employed women with limited leave time are unable to attend the clinic during these hours. Men (partners and clients) may also find these hours difficult. Restricted hours are potentially dangerous for women with complications. Clients with problems may be forced to seek assistance from providers they do not know.	A wide range of clinic appointment times is desirable. Specify evening and weekend hours. Women should be taught exactly where to go for help should a contraceptive problem develop outside of clinic hours.
Forms in clinic fail to include questions about frequency of sexual intercourse, number of sexual partners in the past year and over the past decade, use of illegal intravenous drugs, number of STIs in the past, or number of acts of unprotected intercourse.	Provider's attention not directed to women at high risk for STIs (including HIV), sexual problems, or women at high risk for unplanned pregnancy. Some providers may be less embarrassed to respond to patients' written description than to ask questions.	Forms should include some questions about sexual subjects even if the provider finds them difficult to ask. If clients are literate, self-assessment forms (which women may fill out) may provide a more complete history and minimize embarrassment for client, provider, or both. Provider training should include taking a sexual history, counseling on prevention, enhancing client comfort, and having an open attitude.

Table 24:2 Administrative decisions and their impact on the client/patient (Continued)

Administrative decision	Impact on client/patient	Recommended practices/policies
Clinic management *(continued)*		
A chaperone must be present in the exam room for all pelvic exams, whether the examiner is a male or female.	Patient does not control what is happening to her. This rule may help the clinician to see patients more quickly or it may have just the opposite effect if clinician must wait for the chaperone. Patient may not ask certain personal questions if an additional person is in the exam room. This policy may increase a woman's embarrassment about being examined.	Be guided to some degree by patient's stated preference. Some women would prefer that only one person, the examiner, be present at the time of the exam, and this preference should be respected if possible.
Clients are interviewed in front of other women waiting for services and are examined without adequate privacy.	Clients may feel uncomfortable discussing issues with the provider with others present and will feel acutely embarrassed to be examined without adequate privacy.	If possible, provide a separate room or place a curtain near a corner for individual counseling of clients. Always ensure privacy during exams by providing screens around the examining table and by not permitting guests to interrupt exams.

Table 24:2 Administrative decisions and their impact on the client/patient (Continued)

Administrative decision	Impact on client/patient	Recommended practices/policies
Clinic management (*continued*)		
Providers speak the language of the educated (using very technical terms) to establish a professional identity.	Many potential family planning users do not understand the language of the educated provider. As a result, they are unwilling to seek services at the clinic or, if they do, they do not understand the instructions regarding use of the contraceptive method.	Ensure that at least one person on the staff speaks the language or dialect of most of the clients served by the clinic or program. Make available informational materials in local languages.
To encourage more effective contraceptive use, providers are paid differential incentives for encouraging certain methods, such as the IUD or sterilization.	Providers who are paid more (or given incentives) for providing IUDs or sterilization than for other methods may be tempted to push these methods over others, even when they may be contraindicated for medical or social reasons.	Clients should be informed about a range of methods and assisted in selecting the method most appropriate for them medically and psychologically. The client should freely choose the method without coercion.

Table 24:2 Administrative decisions and their impact on the client/patient (Continued)

Administrative decision	Impact on client/patient	Recommended practices/policies
Clinic management (*continued*)		
The procedures for ordering and shipping contraceptives from central stores to local clinics and providers result in an inconsistent local supply. Although contraceptives are very inexpensive, particularly if donated, their distribution is often handled by supply officers who attempt to ration contraceptives like expensive antibiotics, thus arbitrarily altering supply requests. In response, clinics begin tripling their requirements in anticipation of reductions. The lack of an appropirate supply policy leads to clinics running out of contraceptive supplies.	Clients may visit clinics or providers at great cost or may travel long distances to discover the contraceptive they use is unavailable. They are discouraged from continuing the method and may have an unwanted pregnancy. The motivations of providers as well as their reputations suffer when they cannot provide methods to clients.	Establish a dependable supply of contraceptives from central depots to local providers. Encourage providers to project contraceptive needs and order supplies early. When shortages occur, allow providers to borrow supplies from one another.